

ADOPTION ASSISTANCE AND/OR MEDICAL SUBSIDY APPLICATION

Michigan Department of Human Services

This Application can be used to request support subsidy/nonrecurring adoption expenses and/or adoption medical subsidy. Please check the appropriate box(es)

☐ **Support Subsidy/Nonrecurring Adoption Expenses:** Complete A, B, D, E, F, G and H (See Information/ Directions on Page 4)

☐ **Medical Subsidy:** Complete A, C, D1, D2, D3, D4, G and H (See Information/Directions on Page 4)

A. IDENTIFYING INFORMATION

Child's Name (Last, First, Middle)		Birthdate
Log Number	Social Security Number	Foster Care Case Number
Agency Name		Agency Address

B. DOCUMENTATION REQUIREMENTS FOR SUPPORT SUBSIDY/NRE (See AAM 200, 205, 210, 230, 300, 310)

Check each box below to indicate all required documentation is enclosed when **original** DHS-1341 is submitted.

1. Support Subsidy/NRE/Funding/Rate:

- ☐ **Original** DHS-4081, Adoption Assistance Intent Statement.
- ☐ Copy of the child's birth certificate or other proof of citizenship status, (per FOM 902).
- ☐ Petition or motion that lead to the **most recent** out-of-home placement episode (removal petition).
- ☐ Court order that authorized the **most recent** out-of-home placement episode (removal order).
- ☐ Initial Service Plan (ISP).
- ☐ **Current** Permanent Ward Service Plan (PWSP) or Updated Service Plan (USP).
- ☐ **Current** Parent Agency Treatment Plan and Service Agreement.
- ☐ DHS-352, Initial Determination of Appropriate Foster Care Funding Source.
- ☐ Criminal clearances: BCAL-1326, Licensing Record Clearance Request, for each adult household member and verified LEIN information/results. For out of state placements, a copy of Family Assessment(s).
- ☐ Complete DHS-470, 470A, or 1945, Determination of Care (DOC) Assessment (dated within last six months), signed by the foster parent and DHS supervisor. A DOC assessment for a projected rate must include all approval signatures. A DOC assessment is required for all applications, even if a DOC rate is not being paid.
 - ☐ Professional documentation that supports the DOC rate, if applicable.

For above Level III DOC rates, if applicable:

- ☐ Supporting documentation (dated within last six months).
- ☐ Description of child's special needs and specific information showing how the above level III DOC rate was calculated.

Other Payment Resources – Documentation required if Yes box(es) checked in **Section F:**

- ☐ **Original** DHS-4813, Adoption Support Subsidy Program Other Payment Resources.

C. DOCUMENTATION REQUIREMENTS FOR MEDICAL SUBSIDY- (See AAM 400)

Check if applicable to indicate required documentation is enclosed with application packet.

- ☐ For medical subsidy: Signed professional documentation for each condition (dated within the last 12 months).

NOTE: The Adoption Subsidy Office may request additional documentation.

D. ELIGIBILITY INFORMATION (See AAM 200)

Answer All Yes/No Questions

- | | |
|--|---|
| 1. Have all parental rights been terminated through court action or voluntary release? | 1. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Is the child a member of an American Indian tribe? | 2. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Is the child under Michigan court jurisdiction as a result of an abuse and/or neglect proceeding? | 3. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Has there been an Order Placing Child After Consent? If yes, date: _____ | 4. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Has the adoption been finalized by the court? If yes, date: _____ | 5. <input type="checkbox"/> Yes <input type="checkbox"/> No |

6. Has the potential adoptive family completed and signed Section 1 of the DHS-4081, Adoption Assistance Intent Statement, requesting adoption assistance?	6. <input type="checkbox"/> Yes <input type="checkbox"/> No
7a. Is the child SSI eligible? If yes , attach DHS-4813, Adoption Subsidy Program Other Payment Resources.	7a. <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Is the child age 3 years or more?	b. <input type="checkbox"/> Yes <input type="checkbox"/> No
c. Does the child receive a foster care Determination of Care (DOC) rate Level 2 or higher?	c. <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Is the child being adopted by a relative (see CFG)? If yes , Family Name: _____ Relationship: _____	d. <input type="checkbox"/> Yes <input type="checkbox"/> No
e. Is the child being adopted by the parent of his/her previously adopted sibling? If yes , Sibling's Adoptive Name: _____ Birthdate: _____	e. <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Is the child a member of a sibling group being adopted together and at least one sibling meets one of the above (7a-e) and application for that sibling has been submitted? If yes , All Sibling Name(s): _____ Birthdate(s): _____ _____ _____	f. <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is the adoptive parent the birthparent of the child?	8. <input type="checkbox"/> Yes <input type="checkbox"/> No

E. FUNDING DETERMINATION INFORMATION (See AAM 200)

1. Is the child a child of a minor parent receiving title IV-E foster care payments? If yes, minor parent's name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No DOB: _____																		
2. Was the child previously adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Adoptive Name _____ Did the child receive Adoption Subsidy in a previous adoption? <input type="checkbox"/> Support <input type="checkbox"/> Medical <input type="checkbox"/> None <input type="checkbox"/> Unknown																			
3. Has the child ever been in foster care 60 consecutive months or more? <input type="checkbox"/> Yes <input type="checkbox"/> No																			
4. Criminal History (See ADM 520) List name/DOB of all adult members 18 years or older living in the prospective adoptive parental home: <table border="0" style="width: 100%;"> <tr> <td>Name: _____</td> <td>DOB: _____</td> <td>Name: _____</td> <td>DOB: _____</td> </tr> <tr> <td>Name: _____</td> <td>DOB: _____</td> <td>Name: _____</td> <td>DOB: _____</td> </tr> <tr> <td>Name: _____</td> <td>DOB: _____</td> <td>Name: _____</td> <td>DOB: _____</td> </tr> <tr> <td>Name: _____</td> <td>DOB: _____</td> <td>Name: _____</td> <td>DOB: _____</td> </tr> </table> Do any of the above adults have felony convictions for any of the following: <input type="checkbox"/> Yes <input type="checkbox"/> No <table border="0" style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> • Child abuse or neglect, spousal abuse • Crime against children, including pornography </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> • Violence, rape, sexual assault, homicide • Within the last five years: physical assault, battery, or a drug related offense </td> </tr> </table> If yes, name: _____ DOB: _____ Last Clearance Date: _____ _____ DOB: _____ Last Clearance Date: _____		Name: _____	DOB: _____	Name: _____	DOB: _____	Name: _____	DOB: _____	Name: _____	DOB: _____	Name: _____	DOB: _____	Name: _____	DOB: _____	Name: _____	DOB: _____	Name: _____	DOB: _____	<ul style="list-style-type: none"> • Child abuse or neglect, spousal abuse • Crime against children, including pornography 	<ul style="list-style-type: none"> • Violence, rape, sexual assault, homicide • Within the last five years: physical assault, battery, or a drug related offense
Name: _____	DOB: _____	Name: _____	DOB: _____																
Name: _____	DOB: _____	Name: _____	DOB: _____																
Name: _____	DOB: _____	Name: _____	DOB: _____																
Name: _____	DOB: _____	Name: _____	DOB: _____																
<ul style="list-style-type: none"> • Child abuse or neglect, spousal abuse • Crime against children, including pornography 	<ul style="list-style-type: none"> • Violence, rape, sexual assault, homicide • Within the last five years: physical assault, battery, or a drug related offense 																		

F. OTHER PAYMENT RESOURCES INFORMATION (See AAM 210)

Is the child eligible for or receiving any of the following payment resources?			
1. Supplemental Security Income (SSI)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Retirement, Survivors and Disability Insurance (RSDI)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Veteran's Administration Benefits (VA)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Family Independence Program (FIP) \$ _____ /per month		<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. County Child Care Funds (CCF)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Other: _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No

G. MEDICAL SUBSIDY INFORMATION (See AAM 400)

Does the child have any of the following conditions? (Identify <u>any</u> known conditions.)	
Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Prenatal Drug/Alcohol Exposure (Attach medical birth record).
<input type="checkbox"/>	<input type="checkbox"/> Physical/Medical (List conditions):
<input type="checkbox"/>	<input type="checkbox"/> Developmental (List conditions):

☐ ☐ Mental Health (List conditions):

H. WORKER/AGENCY INFORMATION (required)

<i>Adoption Worker – Printed Name</i>	<i>Email Address</i>	<i>Telephone</i> ()	<i>Ext.</i>
<i>Adoption Worker Signature</i>			<i>Date</i>
<i>Adoption Supervisor – Printed Name</i>	<i>Email Address</i>	<i>Telephone</i> ()	<i>Ext.</i>
<i>Adoption Supervisor Signature (required as verification of a complete application)</i>			<i>Date</i>
AUTHORITY: P.A. 280 of 1939 COMPLETION: Voluntary PENALTY: Program eligibility will not be determined.	Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.		

INFORMATION/DIRECTIONS

GENERAL INFORMATION

Adoption Worker completes this form when a family has been identified as an appropriate family to adopt the child and the family is requesting a determination of eligibility for Adoption Support Subsidy and Nonrecurring Adoption Expenses (NRE) and/or Adoption Medical Subsidy.

- **Each section of the application must be completed in its entirety** and required supporting documents must be submitted with the application. All Yes/No questions must be answered.
- Complete the DHS-4814, Nonrecurring Adoption Expenses Application/Agreement For A Child Without Support Subsidy, when the prospective adoptive family is not requesting a determination of eligibility for Adoption Support Subsidy, but is requesting a determination of eligibility for Nonrecurring Adoption Expenses.
- Complete the DHS-1341 application when the prospective adoptive family is requesting Adoption Support Subsidy, Adoption Support Subsidy and Adoption Medical Subsidy, Adoption Medical Subsidy only or when adding conditions after an initial application has been submitted.

A. IDENTIFYING INFORMATION

- Complete all information regarding the child and the adoption agency in this section.

B. DOCUMENTATION REQUIREMENTS FOR SUPPORT/NRE

- Check each applicable box to verify required documentation is enclosed with the application packet.
- The Adoption Subsidy Office may request additional documentation during the review process.

C. MEDICAL SUBSIDY

Attach professional documentation.

D. ELIGIBILITY INFORMATION (#'s 1-8)

- Answer all Yes/No questions and attach required supporting documents.
- Clarifications:
 - #3. In most termination court orders, the order will have a N/A (Neglect/Abuse) included in the court file number.
 - #6. The family must sign the DHS-4081 in only one section. The ASO accepts only the original signed unaltered form.
 - #7a. A child receiving SSI benefits only (no foster care payment) may be eligible for adoption support subsidy.
 - #7b. The child must be at least age 3 by DHS-1341 form completion date.
 - #7c. If a child receives an above level III DOC rate, the following documentation, in addition to the above, must be submitted with the application: documentation identifying how the level IV rate was determined and a copy of the most recent request/approval by the appropriate DHS Manager (dated within the last six months).
 - #7e. Adoption support subsidy eligibility is not required for the previously adopted sibling.
 - #7f. The plan must be for the sibling group to be adopted together at the same time. At least one sibling must qualify for the Adoption Support Subsidy Program as an individual.
 - #8. A child being adopted by a birth parent is not eligible for adoption subsidy programs.

E. FUNDING INFORMATION

- #4. Provide applicable information concerning criminal history of any member in the prospective adoptive parent(s) household. Reminder: attach BCAL-1326, Licensing Record Clearance Request, for each adult household member.

F. OTHER PAYMENT RESOURCES INFORMATION

If Yes for any question, complete and attach the DHS-4813 Adoption Support Subsidy Program Other Payment Resources.

G. MEDICAL SUBSIDY ELIGIBILITY INFORMATION

- Check applicable boxes, list conditions, and submit current supporting professional documentation.
- Signed professional documentation (dated within the last 12 months) identifying the condition(s) and providing status and treatment of the condition(s) must be submitted with the application packet, for medical subsidy.

Note: Following the adoptive placement an application is made by the adoptive parent by using DHS-1341-A, Parent's Application For Adoption Medical Subsidy For An Adopted Child.

H. WORKER/AGENCY INFORMATION

- Sign the DHS-1341 as verification of all information provided in the application packet.
- The adoption supervisor must sign the DHS-1341 confirming that the application packet is complete.

APPLICATION SUBMISSION

Mail the completed application DHS-1341 and all required supporting documentation to:

Adoption Subsidy Office – Eligibility Unit
Michigan Department of Human Services, Suite 412
P.O. Box 30037
Lansing, MI 48909